VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetic Division of The National Federation of the Blind

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Our New Newsletter Name

We previously called our newsletter *The Diabetic Support Network*. The board of Diabetic Division of the National Federation of the Blind (NFB) elected to hold a nationwide "name the newsletter" contest with the winning prize being $100. Many fine entries were submitted, and at this year's NFB National Convention in Kansas City, Mo., the "name the newsletter" contest committee met and decided on the winner.

The winning entry, as shown on the front page of this newsletter, is *Voice of the Diabetic*. The person who submitted the winning entry was Jeanne Calusine of Bloomfield, Conn.

Thanks, Jeanne, for giving us an official name for our fledgling newsletter and congratulations on winning the $100 prize.

Henceforth, our newsletter will be entitled *Voice of the Diabetic*.

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The Blind in Medical Professions

by Ramona Walhof

I recently attended the convention of the National Federation of the Blind of Delaware, and a discussion occurred that brought home to me a sharp realization that the Job Opportunities for the Blind program is accomplishing things that no other organization or service can do. The speaker was relating some of the experiences of a blind person who is now the head of the Department of Anesthesiology at New York University. This man became blind while teaching Anesthesiology at the University of Kentucky. He continued to do his work admirably for some time and was offered the position at NYU, which he accepted, and he has worked in his current position for several years. The speaker who related this man's experience said (as an aside to the audience) that: Of course, it isn't reasonable to expect that blind people can be successful physicians. Nobody would want to go to them for treatment. This man is in a very exceptional situation.

Federationists will not be surprised to know that there were individuals present in the audience who took the speaker to task for this statement. They said: What about David Hartman? A lot of people thought he couldn't and shouldn't be permitted to go to medical school and practice medicine. But he did, and he is.

There ensued some discussion. Is it reasonable for a blind person to practice medicine? Are there essential duties a blind person cannot perform? Is it reasonable for him or her to depend on an assistant for some things? Will patients have confidence in a blind physician? What about surgery? What about nursing? Who should make the decision about what is reasonable for a blind person to do in medicine and what isn't?

I realized that Job Opportunities for the Blind has been accumulating data in this area for at least two years and that we have access to and input from blind persons throughout the country. This means that what happens in Kentucky, New York, and Louisiana is likely to benefit those in similar situations in California, South Carolina, and Michigan. JOB serves as a national melting pot for collecting and disbursing data about the experiences of blind persons in employment and in preparation for employment throughout the country. It is not the only national service or organization attempting to do this, but its record is more impressive than any other, and its approach is more optimistic and, therefore, it is moving rapidly into new spheres for the blind.

David Hartman, whose story has been publicized nationally, is the blind man who fought to gain admission to Temple Medical School and won. He completed his medical training, specialized in psychiatry, and is now practicing medicine as a psychiatrist. Mark Ravin, the head of the Department of Anesthesiology at NYU, is blind also. Spencer Lewis was a Family Practitioner in Louisiana. When he became blind he believed he could continue to practice medicine. The hospital said he couldn't. His patients wanted him to. He challenged the decision of the hospital and was permitted (with some limitations) to treat patients there.

When this case was brought to my attention, I must confess that I felt some apprehension. I asked one question: How did his patients feel about it? When I was told that his patients overwhelmingly wanted Dr. Lewis, blind or sighted, to treat them, that was enouch for me. I said to myself, "If my docotr were suddenly to become blind, would that shake my confidence in him?" I knowthe answer. My confidence is in the doctor, nnot in his eyesight, and it would not change. And I said to myself, "Why then should I think that bindness might cause problems for a doctor I do not know? Why should I expect a doctor to be more competent if he can see than if he can't?" I have schooled myself to face squarely such questions, even if the path leads me where this one does. The answer has nothing to do with the doctor; it has to do with my attitudes toward blindness. Although I have confidence in qualified blind people as engineers, secretaries, teachers, machinists, administrators, and janiors — I am still subject to society's approach to blindness. Without reasoning it through, my reaction to a blind doctor was one of fear and concern for his competence. Sucha reaction has grown from the standard notion that blind people are generally incompetent. I have shaken off this attitude painfully, and bit by bit, but not totally. My reaction to Dr. Spencer Lewis taught me something about myself — something which causes me to be very careful about saying to blin persons that sight is required or necessarily a controlling advantage. Certainly, it is an advantage, but we must guard against exaggerating its importance — even those of us who are leading the way to try to demonstrate the competence of the blind.

We must also guard against assuming brazenly that blindness does not prevent a person from doing anything. The time may come when technology is such that a blind person can drive a car or pilot a plane, but the time is not now or near at hand, and it would not help anyone — especially the blind — to pretent that this is not true. If a blind person cannot see to read print comfortably, no pretense or wishing can change the fact. Thus, we must constantly be careful to determine whether seeing is essential to performing a given task, and it's not always easy to know. It is necessary to have knowledge both about blindness and the work to be done in order to have a good chance of finding a method for a blind person to use. I know something about blindness, but I do not know enough about medicine to determine whether a blind person can perform the duties of a doctor or not.

Dr. Spencer Lewis did continue to practice medicine, and his practice increased in size. How can anyone doubt his competence in the face of evidence such as this? If he continued to treat most of his former patients, and new patients came to him as well, (which is what happened) — he was certainly successful as a blind doctor.

(Continued on page 6)

Why Be Identified?

by Karen Mayry

Are you one of the diabetics who wishes not to have others know about it? Many of us have gone through that phase during our lives. Some of us change later and realize that it is not fair to those around us to not know what might be happening to us as we slip into an insulin reaction or head toward a coma. However, others — and certainly this is not true only of diabetics — carry no identification to alert those around us as to the nature of our difficulty. Of course, we want to be treated in the proper manner if we are not able to communicate with others as to our needs. Thus, I feel that the use of a Medic Alert necklace/bracelet is necessary to our well-being. It is a national symbol notifying others that we have special needs regarding our health. The Medic Alert organization keeps an individual's personal medical history on file with a toll-free number to call engraved into the necklace or bracelet. I have several items listed on my necklace. They are: blind, diabetic, kidney transplant, taking steroids, my file number and Medic Alert's phone number which is 209-668-3333. In particular, I feel it is vital to have this type of information in one's wallet or purse if not on one's person. If we attend a meeting where others are unaware of our condition, we are not only being unfair to ourselves but to those around us who wish to help. They will be unable to obtain the best treatment for us should we need it. Let's help them by making a conscious effort to have with us at all times proper medical information.

WRITE FOR INFORMATION TO: Medic Alert Foundation International
P.O. Box 1009, Turlock, CA 95381-1009

Necklace or Bracelet: Stainless Steel — Approximately $15.00

Sterling Silver — Approximately $30.00

Heavy Gold Plate — Approximately $38.00

Toward Independence: An Alternative Technique for Drawing up Cyclosporine

by Ed Bryant

Cyclosporine (CSA) is an immunosuppressant drug commonly used in conjunction with organ transplant operations to prevent the immune system from rejecting the transplanted organ. Historically, throughout the medical profession, there has been a pervasive conviction that blind transplant recipients cannot safely or accurately draw up their own cyclosporine unaided by a sighted person.

The following article postulates a procedure which will allow virtually any blind person to draw up his or her own cyclosporine while still fulfilling the all important dual-criteria of accuracy and safety.

This procedure is not experimental. I am a blind kidney transplant patient and I have used it personally for over three years and have yet to encounter any problems. My hope is that through this procedure, many blind people may be allowed to become less dependent on others in this significant aspect of their lives.

Additionally, I would like to encourage the various professionals within the medical community who deal with blind patients to whom this idea would be applicable to inform them of it. Such a self-help policy for blind people is in both the best interest of society, since it allows we who are blind more of a sense of independence, dignity and self-worth, and of the medical profession since it would free up medical resources such as visiting nurses (who, incidentally, many times are paid by the taxpayer) for use in more pressing medical problems.

HOW TO MAKE A CYCLOSPORINE MEASURING DEVICE (STOPPER)

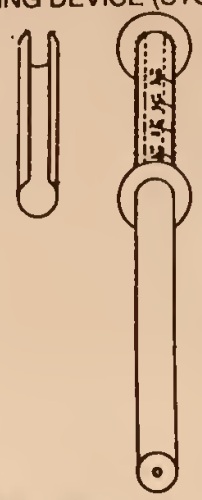

Figure #1: The syringe will hold 4 ml (or 400 mg.) Markings are shown for milliliters 1,2,3, & 4. Each ml is further subdivided into 10 equal parts. Thus each subdivision indicates .1 ml (or 10 mg.)

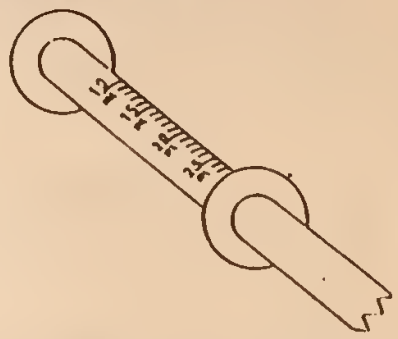

Figure #2: The completed measuring device (stopper).

Materials required: 2 syringes for measuring cyclosporine, 1 single edge razor blade, 1 ruler.

Procedure:

1. Remove the plunger from one of the syringes. Set this plunger aside, you will not need it.
2. Raise the plunger on the other syringe until it reads the proper dosage required for the patients. (i.e. 1 ml or 100 mg, 200 mg, etc.)
3. Measure the distance on this plunger between the finger tabs on the tube and the finger tabs on the plunger for the proper dosage.
4. Take the empty sleeve of the other syringe and cut off a section of the tube which is a little longer than what you measured. (If you only have a 1 ml (100 mg) dosage, you can cut 2 or 3 tubes from this sleeve.)
5. Hold one of the tube sections firmly and cut it length-wise through one side. This is like splitting a soda straw down the edge.
6. Again, holding the same tube section firmly, cut it length-wise a second time to remove the small section down one side of the tube. The section removed will look like a small curved rectangle about 1/8" - 3/16" wide and the same length as the tube.
7. The tube section now looks like the letter "C" and the open side will slip over the plunger on the syringe when the plunger is lifted.
8. Slip the tube section onto the plunger and press the plunger down firmly. Because we cut the tube a little longer, we now need to trim the ends to make them neat and to make the tube section the proper length for the correct dosage. Note: The hard plastic is applicable to the use of files and/or sandpaper for this purpose. Remove the tube to do these final cuts.
9. Slip the tube back onto the plunger to insure that it is the proper length.
10. This tube section is your measuring device. You should cut a second one in case the first is misplaced.

HOW TO MEASURE CSA AND USE STOPPER

1. The bottle of CSA should be sitting on a flat surface such as a table.
2. Insert the CSA syringe into the bottle. Make sure that the plunger is pushed all the way in.
3. With one hand hold the bottle containing the CSA and the syringe and with the other hand slowly pull the plunger out until you have drawn a bit more CSA than the dosage calls for.
4. Insert the CSA stopper onto the syringe plunger.
5. Push the plunger in until it is solidly in contact with the CSA stopper. Note: Always continue to hold the bottle with one hand as it might otherwise tip over and CSA is astronomically expensive.
6. Remove the syringe from the CSA bottle and remove the stopper from the plunger.

You now have the correct CSA dosage in your syringe and are ready to mix it with whatever liquid you use.

To determine how long a bottle of CSA will last, simply divide the CSA dosage (milliliters or milligrams) that you use each day into the total dosage contained in the bottle (i.e., if you use 2 ml each day, then the bottle would last 25 days or, if you use the equivalent amount of 200 mg each day, the bottle would last 25 days). There are 50 ml or 5,000 mg in each bottle. When the bottle gets close to being out of CSA, it is sometimes difficult to accurately draw the correct amount. To insure that the correct amount is drawn, as a safeguard, I assume that each CSA bottle contains only 45 ml (4500 mg) rather than the actual 50 ml (5000 mg).

After using the 45 ml (or 4500 mg), I open a new bottle and after using the same amount from the new bottle, I combine the contents of both the old and new bottles with the help of a small funnel.

It is easy to tell by the weight of the bottle when the amount of CSA remaining is getting low. This same information can also be obtained by gently shaking the contents. (Be sure to replace the cap securely first!) NOTE: If you are ever uncertain about the dosage that you have drawn, do not take it!

Since the daily CSA dosage usually diminishes with time after the transplant, you will need to modify the length of the stopper accordingly each time the dosage decreases. This can be done most easily by utilizing a file and/or sandpaper.

You will find that this device is extremely durable and has an almost indefinable lifespan. I have been using the same piece of tubing for over three years.

A note to medical professionals: We certainly hope that you will pass along this helpful technique to any of your blind patients to whose circumstances it would be applicable. They will appreciate you for it.

A note to patients and consumers: We hope that you will pass along your knowledge of this procedure to physicians, nurses and transplant units to enable them to serve you and others more effectively in the future.

All transplant units should show this method of measuring CSA to blind people. Unfortunately, many people are not aware that blind people are quite adept at handling such a simple task.

The National Federation of the Blind exists to serve all blind people, to eliminate the myth that blindness is synonymous with inability, to accentuate the positive assets and abilities of blind people and to encourage these people to use these assets and abilities to their fullest.

BE INDEPENDENT,
NOT DEPENDENT!

An Endorsement for the Cyclosporine Measuring Device

Sometime back the editor contacted Barb Elick, Chief Transplant Coordinator at the University of Minnesota Hospital, and asked her for recommendations and opinions regarding the CSA measuring device.

The U of M Hospital and staff are pioneers in kidney and pancreas transplantation. For many years they have paved the way in organ transplantation for diabetic patients.

Barb Elick passed the idea along to Nancy Rose-Balamut, Acting Head Nurse of Unit 5C at the U of M Hospital. Unit 5C is the transplant ward.

The following is a quote from a "thank you" letter sent by Nancy Rose-Balamut:

"I showed the nursing staff on Unit 5C. I know they are showing this idea to our patients. Thank you for passing this idea (on) to our transplant patients. It is such a simple idea and yet ingenius."

We, the Diabetic Division of the National Federation of the Blind, sincerely hope that all transplant units will share this CSA technique with their blind or visually-impaired patients who use CSA.

IF YOU WISH TO JOIN THE DIABETIC DIVISION, SUBSCRIBE TO **Voice of the Diabetic**

AND/OR MAKE A DONATION, PLEASE COMPLETE THIS APPLICATION

Membership in the Diabetic Division of the National Federation of the Blind (NFB) costs $2.00 yearly, tax deductable. However, production costs for **Voice of the Diabetic** run about $6.00 per year. Members are invited to cover this cost. Please fill out the following:

☐ I wish to join the diabetic division of NFB. Enclosed is my donation of at least $2.00.

☐ I do not wish to join at this time, but enclosed is my donation for at least $6.00 to start my subscription.

☐ I wish to receive my newsletters in print only.

☐ I wish to receive my newsletters on cassette tape only.

☐ I wish to receive my newsletters both in print and on cassette tape. (Cassette tapes are provided to blind or visually impaired at no additional charge.)

☐ I wish to support the Diabetic Division with my contribution of $----.

Please print clearly:

Name----------

Address----------

City----------State----------Zip----------

Telephone number — ( )----------

Send this application or this requested information along with your donation to our treasurer, Carol Anderson, 23 Lake Shore Drive South, Randolph, NJ, 07869. Phone: (201) 895-3166. Please make all donations payable to the National Federation of the Blind.

Legislative Update U.S. Senate Bill S.2536

The U.S. Senate Bill S.2536 is called "The Immunosuppressive Drug Therapy Act of 1986". This bill provides for block grants to states to pay the cost of immunosuppressive drugs for organ transplant patients.

The National Federation of the Blind at this year's national convention in Kansas City, Missouri, unanimously passed a resolution to support this bill. Many blind or visually impaired diabetics and others will need organ transplantation (usually a kidney) and will not be able to afford the astronomically expensive cost of immunosuppressive drug therapy.

The Congress finds and declares that:

1) new immunosuppressive drug therapies have made cadaver organ transplants increasingly successful;

2) approximately 25 percent of individuals needing organ transplants have no private insurance coverage for immunosuppressive drugs and are not eligible for coverage for such drugs under the Medicaid program; and

3) the use of immunosuppressive drug therapy could result in savings in medical costs, since —

A) the cost of hemodialysis is between $18,000 and $25,000 per patient per year;

B) the cost of immunosuppressive drug therapy is between $5,000 and $7,000 per patient during the first year of therapy; and

C) the cost of a successful renal transplant is between $25,000 and $35,000 per patient during the year in which the transplant is performed, $6,000 per patient during the first year after the year in which the transplant is performed, $4,800 per patient during the second year after the year in which the transplant is performed, and $2,900 per patient during the third year after the year in which the transplant is performed.

People eligible under this act are those who do not receive total reimbursement for immunosuppressive drug therapy from private insurance, title XVII of the Social Security Act or the state's medical plan under title XIX of such Act.

We, the National Federation of the Blind, strongly endorse this bill which, if passed, would mean that megabuck amounts would be saved, and lives would be spared as well. Many transplant recipients would again become productive, contributing members of society and save taxpayer dollars.

We ask that our reading audience write and/or contact their two U.S. senators and U.S. House representative(s). Tell them that you are in favor of U.S. Senate Bill S.2536, "The Immunosuppressive Drug Therapy Act of 1986." When writing to U.S. Congress members, we recommend that you ask a direct question: *Have you signed your name as a sponsor of this bill?* This will prompt a straightforward reply from them.

Hopefully an impressive response from our readers and other concerned citizens will result in the passing of this important legislative bill.

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NOTE: Are there any other committees that you think might be needed? We do need someone to be chairperson of the Insulin Pump committee; do you know someone who uses an insulin pump that might be interested in this position? If you can help with any of the above, please contact Karen Mayry.

A Look at the Eye Care Delivery System

We are thankful to Valorie Powell, a member of our organization, for supplying us with the following article. Valorie is a health educator by profession and has undergone proliferative diabetic retinopathy. She exemplifies the capabilities of blind or visually impaired people.

by Valorie Clare Powell

Did you ever wonder what the typical experience of a diabetic person was in terms of eye care delivery? Of course you already know what your own experience was, but was it typical? How does your own experience stack up?

In order to look into the extent of the problem of diabetic retinopathy, the Utah Diabetes Control Program conducted a survey during 1985. Surveys were given to people who currently have diabetes; some people had retinopathy while most did not. The purpose was to determine the typical experience of a diabetic person in relationship to the eye care delivery system (defined as visiting an ophthalmologist, optometrist or optician).

Based upon earlier surveys, it was estimated that approximately 11% of the diabetic population in Utah had been diagnosed as having retinopathy. Sixty-three percent of the people with retinopathy had had some kind of laser treatment.

The newer survey asked diabetic people, both with and without retinopathy, the following kinds of questions:

- why were eye exams sought?
- how was it learned that retinopathy was a complication of diabetes?
- what type of eye doctor was chosen and why?
- why was the particular type of doctor chosen?
- what procedures were performed during a typical exam?
- were follow-up appointments suggested and kept?

What the survey results showed were that most diabetic people enter the eye care delivery system because they experience a visual problem rather than because they are seeking preventive care. This by itself is important because by the time symptoms of diabetic retinopathy present themselves, it is often too late to receive the most effective care.

Respondents to the survey reported that their primary care physicians recommended regular eye examinations to them less than 50% of the time. Half of the people responding were not asked to return for a regular eye exam by their eye care providers. And less than half (only 3%) of those people without retinopathy actually did report that they had an annual eye exam. Annual eye exams are critical in the diagnosis of retinopathy, but it is not surprising that there were so few of these exams when people do not have them recommended by their physicians and eye care providers.

Sixty-six percent of the people who had retinopathy first learned that they were at risk for it from an eye doctor. In other words, they must already enter the system to learn that they are at risk for retinopathy. This points to a need to strengthen education and referral.

Most people chose an ophthalmologist as their eye care provider, especially if they had been diagnosed as having retinopathy. The opinion of a family member or friend weighed most heavily in choosing a particular doctor.

In order to diagnose retinopathy, the eyes must be dilated. Dilation of the eyes was used as minimum criteria for an adequate eye exam. This survey showed that in urban areas of Utah, most people did receive adequate eye exams. Surprisingly however, less than half of the respondents in rural areas received adequate exams to diagnose retinopathy.

Attitudes of the respondents indicated that both Type I and Type II diabetic people have a false sense of security regarding diabetic retinopathy. Type II (non-insulin dependent) diabetic people may believe that retinopathy only affects the more severe, Type I (insulin dependent) person. And both types falsely believe that they can accurately detect and correct symptoms related to diabetic eye disease. People with retinopathy indicated that they would have liked to receive more information about retinopathy from their doctors.

What this information indicates is that a diabetic person often has difficulty entering the eye care delivery system because education and referral are lacking. Once they enter the system they are not always assured of receiving an adequate eye exam or of being followed-up.

These are serious problems which need to be addressed. Hopefully studies, such as the one just described, will document the problem and promote action now and in the future.

Questions regarding the survey on diabetic retinopathy in Utah, as discussed in this article, may be addressed to the Utah Diabetes Control Program (801) 538-6141.

Editor's Epithet: According to Roy A. Goodart, M.D. (who coauthored the survey with Valorie Powell): "There are an estimated 27,000 diabetic people in Utah. Eleven percent or nearly 3,000 of these people are estimated to have diabetic retinopathy, and many more are at risk to develop it. As diabetic retinopathy is the leading cause of blindness for people under 40 years of age in America, the findings of this study can enhance our efforts to understand the nature of this problem."

Yes, blindness or visual impairment is a prevalent complication of diabetes, and we are cognizant that there are many more unfortunarte ramifications of our disease. One of these unfortunate complications of visual impairment or blindness is widespread societal misconception concerning the capabilities of blind people. If you would like information concerning any area of blindness or visual impairment, please contact us:

National Federation of the Blind
1800 Johnson Street
Baltimore, MD 21230
(301) 659-9314

Ask Dr. James

by Ronald James, M.D.

Please note: If you have any questions for Dr. James please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.

Question 1: Since diabetes is a disorder of the endocrine system, how does diabetes affect other hormonal functions of the body, such as ovulation?

Answer 1: Insulin, and thus diabetes, affects other hormonal functions. It is well known that young ladies with poorly controlled diabetes may have a delay in the onset of their menstrual periods and thus ovulation. Their periods may be irregular and they often skip them. This may improve with good diabetes control. It is also well established that both glucagon and growth hormone are increased in many diabetics.

On the other hand, the function of the other endocrine glands may have an effect on the diabetes. For example, excessive production of growth hormone by the pituitary and of cortisol or aldosterone by the adrenal gland may cause or worsen the diabetes while inadequate production of growth hormone or cortisol may make the diabetes milder or cause hypoglycemia.

Question 2: If a diabetic has chronic complications such as retinopathy or kidney disease, why are both organs, eyes and kidneys affected at the same time?

Answer 2: Insulin controls chemical processes throughout the entire body. Therefore both the eyes and kidneys are subjected to the same level of diabetes treatment and control for the same periods of time. Thus it is not surprising that both could be affected at the same time. On the other hand, they are not always affected simultaneously. Frequently the diabetes will have affected one without the other, usually causing retinopathy without kidney disease.

Question 3: If a diabetic has liver complications, how does this affect glucose storage for use by the body during insulin reactions?

Answer 3: Mild or moderate liver damage will not have much effect on glucose stores and the maintenance of normal glucose levels. Only severe liver damage (probably loss of at least 80% of the liver's function) will affect glucose storage and therefore the glucose supplied by the liver during an insulin reaction. In the latter case the blood glucose may go high following a meal because of poor ability of the liver to take up glucose and go low later because of poor stores in the liver.

Question 4: I am told that the non-insulin dependent, or type 2 diabetic, will not develop chronic complications. Is it actually true that because I am a type 2 diabetic I will not develop severe complications?

Answer 4: The type II, non-insulin dependent diabetic may develop all the severe chronic complications of diabetes. He/she is most likely to develop those complications related to arteriosclerosis (hardening of the arteries). They include cerebrovascular disease often leading to a stroke, coronary artery disease that may result in a heart attack, and poor circulation to the legs and feet that may cause gangrene and the need for an amputation.

Question 5: If insulin becomes outdated or turns bad, will it change color or is there any visual way of telling that it might be bad?

Answer 5: When insulin goes bad, it may or may not change color. In some cases the cloudy insulins form clumps that may adhere to the bottle and do not break up and go into suspension when the bottle is rolled between the hands. Regular insulin may form a cloud, precipitate, or clumps, in which case it should not be used.

Diabetic Emergencies

(Pamphlet published by U.S. Department of Health and Human Services)

Insulin reaction or insulin "shock" can occur if the diabetic's blood sugar level falls too low, a condition called hypoglycemia. It results from too much insulin in the system caused by too large a dose of insulin, too little to eat, over strenuous exercise, or failure to eat shortly after insulin is taken.

Although each person may react differently, common symptoms of insulin reaction include trembling, sweating, and nervousness. Some diabetics may experience hunger, headache, nausea, drowsiness, or symptoms of inebriation. In severe cases of insulin shock, the diabetic may even become unconscious.

A careful blend of correct amounts of insulin, exercise, and food can usually prevent insulin reaction. When hypoglycemia does occur, however, most diabetics sense early warning signals and eat or drink something sweet to raise the amount of sugar in the blood. If a person is unconscious, an injection of glucose solution or the hormone, glucagon, should be administered.

Ketoacidosis, a more serious emergency than insulin shock, results from too little insulin in the system. When the body is unable to use glucose for fuel, it draws on its own stores of protein and fat for energy. Acids, or "ketones," produced by the excessive breakdown of fat then accumulate in the blood stream quicker than the kidneys can dispose of them.

Unlike insulin reaction, the symptoms of ketoacidosis generally develop slowly over a period of days. The diabetic may begin to experience abdominal pain, nausea and vomiting, rapid breathing, and drowsiness. If left untreated, ketoacidosis can progress to coma and death.

Ketoacidosis can be prevented by careful daily evaluation of insulin needs. Particularly stressful situations such as illness or surgery may require increased amounts of insulin. Most importantly, a diabetic should never skip or delay an insulin injection.

Easy Enchilladas

by Marsh Mayry, Rapid City, SD

8 Flour tortillas
15 oz. 1 large can chili without beans
14 oz. 1 can Enchilada sauce (we use mild)
8 oz. 1 small can tomato sauce
Chopped onion
Grated cheese — sharp cheddar

Instructions:

Grease 9x13 cake pan. Set oven to 325 degrees. On each tortilla put ¼ cup chili, 3 tbsp. chopped onion, 1 tbsp. shredded cheese, and 1 tbsp. Enchilada sauce (if sauce is too hot dilute with tomato sauce). Fold over. Hold together with toothpick if desired. Place in pan. Put left over onion, cheese and sauce over the top of tortillas. Bake 30 minutes. These can also be placed in foil before baking. Freeze and use later for a quick supper.

Yield, number of servings: Eight
Calories per serving: 225
Diabetic exchange: 2 bread, 1½ fat

New Method To Promote Healing

by Ken Carstens

The day was a bright, unusally warm day in September. The place was the Minnehaha Parkway, Minneapolis, Minn. A bicycle and hiking trail wound its way along beautiful Minnehaha Creek across streets and avenues around Lake Nakomis and then back to the starting point. About 40 people, most of them blind, gathered at the starting point. Most of us were members of the National Federation of the Blind of Minnesota. The occasion was the fourth annual Move-A-Thon to raise funds for the State affiliate. We had taken pledges for every kilometer completed of the twenty kilometer course. The night before, we had loaded two tandem bikes on top of our station wagon and made the two hundred mile trip from the Iron Range in northern Minnesota. Four members from our chapter made the trip, my wife and I, Dave Hardy who rode the other tandem, and Jan Dowel who walked the course. Jan, my wife Linda, and I stayed with our friends Steve and Nadine Jacobson, who are members of the metro chapter. Early the next morning we drove the few blocks from their home to the parkway. We unloaded the bikes, checked in, and started the course, stopping at the check points to chat and get a refreshing drink of water. After we completed the course, there were sandwiches and coffee for all, provided by Peggy Chong, the fund raising chairperson.

After a short meeting at the home of our state president, Joyce Scanlan, we made the trip back to the Iron Range.

The next day after taking a bath I noticed a blister on top of my right foot. This surprised me as we had ridden over four hundred miles already that summer. I also was wearing an orthopedic shoe with a molded insole. Evidently the hot muggy weather had caused my foot to swell. The many twists and turns of the trail also contributed to the cause of the blister. My wife and I work with woodcraft, and the following week, while at a sale at St. Cloud, Minn., my foot started to hurt and became red and swollen. I contacted my doctor at the U of M hospital, and she recommended we make the fifty mile trip so she could look at it. I had already lost one leg soon after my kidney transplant in 1975. Taking no chances on losing this one too, I was admitted to the hospital. After four days of intravenous antibiotics, the swelling and redness left. Before leaving, a representative from the Wound Healing and Limb Salvage Clinic visited me. They explained an experiment they were conducting to help promote healing on diabetics like myself. The procedure consists of drawing about four ounces of blood. The healing platelets are removed from the blood and made into a paste. This platelet-derived wound healing factor paste is applied daily until the wound is healed. Every two weeks blood is drawn and new paste is made. Two jars of the paste are made, and one must be kept frozen until the first jar is used, as it will only keep one week even though it is refrigerated. At each visit the wound was examined for infection and also to check the progress of healing. Pictures were taken of the wound, also to show progress. At the time of my involvement, I was told that the procedure was ninety-eight percent successful on all those involved in the experiment. I feel that it speeded up the healing of my ulcer considerably. The only inconvenience for me was the two hundred mile trip every two weeks for the clinic visit.

I have been a diabetic for almost forty years. Dr. Knighton, Director of the healing clinic, expressed his opinion that all diabetics should wear custom made shoes. Therefore I was fitted for a shoe a few days later. A plaster mold is made of the foot, and a shoe is made to the exact shape of the foot. In this way there is no pressure point on any part of your foot. The shoe also has a rocker sole. The sole is made round so it will not change shape after it is worn, which could also change the pressure points. I have found this shoe, although rather expensive, to be one of the most comfortable I have ever worn.

It is my personal opinion that many amputations can be avoided by the use of this healing process and also by the use of custom made shoes.

It's That Time Of Year

by Ed Bryant

Suggested guidelines for selling NFB products at retail outlets.

The Christmas season is traditionally a big fund-raising time for our organization, The National Federation of the Blind (NFB). Many of our NFB chapters sell candy and other items in front of stores such as supermarkets and discount outlets. The following are suggestions that will help raise additional money, improve our personal public relations with customers and store management, and show the public that, although many of us "happen to be blind", we are active and participating in society.

When working at stores, there are many tools in the fine art of salesmanship that, when used correctly, will help each of us as individuals and, more importantly, help local chapters of NFB:

1. Store management should be extended the courtesy of a person-to-person visit when arranging the sales promotion of his/her store. As soon as possible after our promotion we should thank store management for allowing us to work at the store.

2. The first rule of selling is always sell yourself. This is initiated by a nice, warm, friendly smile. The second step is to enthusiastically extend your hand for a handshake. This means a firm handshake with conviction so that the store manager knows you are pleased to meet him and excited about doing business at his/her store. The art of handshaking is a subject all in itself. Please remember not to shake the person's hand so hard that you remind him of a bone crusher; equally important, do not shake his hand so loosely that you remind him of a jellyfish. A handshake means a lot in the world of business, and each of us will be well rewarded by remembering this simple message.

3. DISPLAY SIGNS: Always put the name of our organization, the National Federation of the Blind, at the top of the display sign in large, bold print. We should always note on the sign that we are a non-profit organization, and that, all donations are appreciated and tax-deductable.

4. ITEMS FOR SALE: The main commodity sold most often is candy. It is also wise to offer supplementary items subh as small novelty products. With just one item our sales effectiveness is sometimes limited.

5. DISPLAY OF MERCHANDISE: Always maintain a nice display of candy on the table, as people's attention will be more readily captured. Also we should give each bustomer some NFB literature.

6. PLACEMENT OF DISPLAY SIGNS: When possible, they should be placed at eye level. This will draw the most attention. Due to space restrictions it is sometimes best to tape the signs from the edges of our tables.

7. PLACEMENT OF CARD TABLE: We should always try to place our table close to the doors; however, we must make certain that it is not in the way of customers or grocery carts.

8. PERSONAL LOCATION: We should stay out of the way of electric doors, and, if we are carrying a cane, we must make certain that they do not interfere with store traffic.

9. SCHEDULING: If possible we should schedule both a male and a female at each location, and there should always be a cane or guide dog in sight. What better way to exemplify our abilities than to display these symbols of our independence.

10. MONEY MANAGEMENT: It would be wise not to use a cup to collect money. We should consider the psychological effect. People look inside the cup and see only change; therefore, in their minds when they give a donation they are thinking in terms of coins instead of paper money. We should also remember that, unfortunately, many people picture blind people as standing on a corner, holding out a cup, asking for money. This stereotype does not apply to the vast majority of blind people. Some NFB chapter members use money aprons which are quite handy and efficient.

11. COMMUNICATIONS: We have had much success by asking each customer for a donation and asking them to buy a box of candy to help the National Federation of the Blind. Usually we will do better to get the customer's attention before letting them know how much our products cost. We should gear our presentation toward capturing the customer's imagination. Two keys to successful communication are congenial smiles and enthusiastic voices.

12. THANK YOU LETTER: At the conclusion of any fund-raising event, a formal thank you letter to store management is definitely needed. If the event is selling candy in front of stores, and we will be there on several different dates, then a thank you letter is needed at the conclusion of the selling season.

The aforementioned materials can be extremely advantageous to us if we will make a dedicated effort to project the name of the National Federation of the Blind by seeing how well we can do at selling our products.

EDITOR'S NOTE: A formal "thank you" letter can be a great asset to any fund-raising prootion. There are, of course, numerous ways of structuring a letter. Following is one example:

(Sender's name)
(Sender's address)
(Date)

(Store manager's name)
(Store manager's address)

Dear_____,

With the conclusion of our (year) candy fund-raising season our group, the National Federation of the Blind (NFB), extends to you our sincere thanks for allowing us to sell candy at your store. The entire_____chapter of NFB applauds you for providing this meaningful assistance to our organization.

The National Federation of the Blind is a non-profit, charitable organizaton. Our goals are the employment of the blind, a general acceptance of us as productive, capable citizens and security, equality and opportunity for ourselves. The money obtained through our fund-raising efforts will be used in many different areas of need to help and support our fellow blind citizens.

We also want to extend our thanks to your staff since, without exception, they were extremely courteous to our members and wished us well during the candy selling campaign. You are probably aware that many of your customers made very positive comments regarding your store. Again we, the National Federation of the Blind, wish to thank you for allowing us to sell candy at your store. If we can help you or answer any questions, please feel free to contact us at any time. We are looking forward to working with you in your store again.

Best wishes for a good and profitable year.

Sincerely yours,

(Sender's name)

DIABETES EXPERIENCE

by Harold Pigsley

I am Harold Pigsley, 64 years of age and from Rapid City, South Dakota. I have been an insulin dependant diabetic for 40 years. I was wounded by shrapnel from an artillery shell on September 20, 1944, in Belgium during World War II. The injury was in the pancreas area in the back. I returned to my combat unit from the 77th Evacuation Hospital after the shrapnel wound had healed on the outside where the shrapnel pierced my back. Following my return to combat, I had frequent abdominal pains in the stomach and pancreas area to the back.

On November 22, 1944, I was wounded in the right leg and evacuated from Germany to England. Upon arrival at the 114th General Hospital, I had gangrene in my leg below the knee. The doctors discussed amputation of the leg. One of the consulting doctors suggested running gauze through the two shrapnel wounds in my leg and pouring raw penicillin on the gauze between the wounds. They were giving me the maximum amount of penicillin by injection. Penicillin was a relatively new drug at this time. It was very effective. After a few days, the gangrene cleared up. The doctor cut away the dead particles of tissue and the leg healed. My blood tests showed varying amounts of sugar. I believe at this time diabetes was oncoming. However, I was not then diagnosed as a diabetic. I was returned to the United States for a medical discharge from the Army. I was discharged with 10% disability on my leg, but no rating on the stomach condition because the doctors had not made a complete diagnosis on the abdominal condition. After three exploratory operations on the abdominal area, the doctors at the Veterans Administration Hospital in Minneapolis, Minnesota, diagnosed the problem was an injury to the pancreas, the stomach and intestines, which caused Chronic Cystic Fibrosis of the pancreas. The common duct of the pancreas was explored and sections of the pancreas, stomach and intestines were removed. So I have been an insulin dependent diabetic since that time in 1946.

I was self-employed most all my working years because every time I applied for a job I would be turned down because of my health from diabetic complications from years before. Diabetics experienced much employment discrimination at that time.

I was in the automobile business for six years as a partner and my diabetes got out of control. I had to retun to Minneapolis Veterans Hospital for further surgery and hospitalization for nine months. Because of digestive problems related to my pancreas injury, I was a guinea pig for various experimental techniques, one of which was drinking ground, raw pancreas taken from a cow. This was taken with tomato juice.

When I returned home, I purchased a small trucking business from my father as he was retiring. During the next eleven years, I had to return to the hospital again and again, so I was forced to sell the trucking business. After months of hospitalization, I returned home and was unable to find a job. I purchased a bar and package liquor store in Wall, South Dakota. Four and a half years later, in 1971, I was forced to sell out as my eyes were beginning to give me trouble. In January, 1972, I went to Denver, Colorado Veterans Hospital and they began giving me laser treatments for diabetic retinopathy. I lost the sight in the left eye and then they began treating the right eye with the laser. To date, I have had 21 laser treatments and have only tunnel vision with less than 8% peripheral vision. In 1973, the doctors did a vitrectomy on my left eye, but were unable to regain any vision because of damage to the optic nerve. I still return to the ophthalmologist every three to four months so they can keep the condition stabilized.

In 1977, I was contacted by Karen Mayry along with several people with vision problems. We proceeded to form the Black Hills Chapter of the National Federation of the Blind. My wife and I are charter members and we are still very active in our fund raising projects. I am a board member of the Black Hills Chapter and serve on several committees. The work in the chapter is very gratifying for us. I have enjoyed reading the first two issues of the Diabetic Support Network Newsletter very much.

Note from Karen Mayry: Harold Pigsley is an extremely fine example of one who, despite the many roadblocks in his life, maintains an optimistic viewpoint and serves as a role model to others. In addition to being on the Black Hills Chapter Board, he has served as Vice President of the N.F.B. of South Dakota. Indeed we are fortunate to have him as part of our movement.

The Blind in Medical Professions

(continued from page 1)

When the hospital relented and permitted Spencer Lewis to treat patients there, they did not permit him to deliver babies. Again, he and his patients considered this unreasonable, and he did deliver babies at home and in the clinic. In fact, he delivered a baby for Federationists Joanne and Joseph Fernandes — new patients who got to know him after he became blind.

In the spring of 1982, Dr. Lewis died, and he is missed by those he treated. The work he did lives on, for it is conclusive evidence that a blind person can practice medicine successfully and that he can gain the confidence of large numbers of patients. And the work of Dr. Spencer Lewis lives on in another way as well.

He realized that it is important for the American Medical Association to recognize that competent performance as a physician need not be impaired by blindness or other physical handicaps. Therefore, he and his wife set about contacting blind doctors and those who are losing vision throughout the country. JOB will carry on the effort to help blind doctors gain acceptance in practice. We belive that more than twenty blind doctors are currently practing medicine successfully in this country.

But there are numerous other types of work in medicine, and blind persons have been discouraged, if not barred, from entering most of them. This, in spite of the face that there have been a few isolated successes in almost every area of employment and training. Anthony Burda is a trained phrmacist, and he is blind. When he applied for a license as a pharmacist in Illinois, he was told that as a blind person he could not be licensed. With Federation assistance, Tony Burda was able to receive his license as a pharmacist, and he is now employed in the Poison Control Department of St. Lukes-Presbyterian Medical Center in Chicago.

Some states have regulations denying licenses to blind persons who are qualified to be occupational therapists and physical therapists. We know of blind people who are successfully employed by hospitals doing both types of work. The Federation has actively fought legislation and regulations which would limit job opportunities for the blind in these areas, and we will continue to do so. Job Opportunities for the Blind will continue to be in touch with blind persons who are in training and who are employed in these professions. We are in touch with blind nurses. One is now the Director of the School of Nursing at Mercy Hospital in Des Moines, Iowa. One has experience in the administration of a nursing home. We are also in touch with blind nurses who are competent, but have not yet been able to obtain employment. In addition, we know blind persons who would like to become nurses, but thus far have been unable to gain admission to a school of nursing. Job Opportunities for the Blind is working on this matter. It is not reasonable to deprive a blind person of an education just because there may be some positions in the field that do require sight. There are also many which do not.

The April, 1982, edition of the JOB Recorded Bulletin carried two articles which are relevant to the success of the blind in medical professions. One dealt with employment opportunities in pharmaceutical sales. This is clearly an area where blindness would not be a disadvantage. A Bachelor of Science degree in nursing or a degree in pharmacy is important to anyone entering the field. Another article from the JOB Recorded Bulletin for April dealt with the expanding scope of nutrition in health care — again an area where blind people should be able to compete with no difficulty, given the opportunity.

It will take some study and experience to determine exactly which jobs in medi11216403cine can be performed competitively by the blind and which cannot. It is clear that we do not yeat have all the answers. JOB will continue to work with blind persons, training programs, and employers to develop new opportunities and determine what is reasonable. However, it is clear from the few examples cited here that the horizons for the blind in the medical field are more far-reaching than most people (including many competent and forward-looking blind persons) have though. There was a time when blind persons were encouraged to enter the field of chiropractic medicine. That time is no more, even though blind chiropractors have been and are extremely successful. There are those who say that blind people cannot now compete because the field of chiropractic medicine is being upgraded. It is depending more on X-rays and other lab work. Blind chiropractors regard this upgrading as a good thing, for them as well as for the sighted. They resent and deny the implication that the blind cannot meet the higher standards.

Blind persons are doctors, pharmacists, nurses, therapists, and chiropractors. What is true of employment for the blind in the medical profession is what we have known for many years about employment for the blind generally. The biggest problem we face is an attitudinal one. We must fight for the opportunity to compete. Once we get the opportunity, there is no doubt that we can succeed.

Job Opportunities for the Blind is actively working to develop new and better opportunities for blind persons in the medical professions and in all other kinds of work. If you know of persons who have encountered difficulties because of blindness when they wished to continue or begin employment in any of these professions, refer them to JOB. If you know of blind persons who have experiences that might be beneficial to others, please tell JOB about them. We are moving ahead in the development of more and better employment opportunities for the blind because of cooperation from thousands of persons across the country. We must keep the momentum going. We have too much at stake to stop.

Letter to the Editor

Dear Mr. Bryant:

Could a free subscription to The Diabetic Support Network newsletter be provided for the use of the blind and physically handicapped who listen to the Evergreen Radio Reading Service here in the state of Washington?

The Evergreen Radio Reading Service of the Washington Library for the Blind and Physically Handicapped provides information to individuals throughout the state who cannot read standard print because of a visual or physical handicap. The radio broadcasts current information such as newspapers, grocery ads, magazines, science information, special news for the handicapped, etc. We broadcast throughout most of the state of Washington and currently reach about 1700 homes and institutions over our closed circuit sub-channel radio. The 92 hours of programming that we offer each week are totally volunteer produced.

Articles from The Diabetic Support Network would be used on our Diabetes Forecasl program as well as a source for recipes for Kitchen Corner.

Your consideration of this request would be very much appreciated. Thank you.

Sincerely,
Jan James, Director

P.S. We received the April-June issue and were very impressed with it.

Editor's Comments: We thanked Ms. Ames for her comments and told her we would provide our newsletter on a complimentary basis. This is not usually possible as money must be spent judiciously. However, in this case hundreds of listeners would benefit from the information we provide. Membership dues are now $2.00 kper year which includes our quarterly newsletter. If a person is blind or visually handicapped they can receive our publication on cassette tape at no additional charge. Again, Ms. Ames, thanks for your interest.

Recipe Corner

Send your great recipes to the editor, Ed Bryant. He is the official taste tester and needs recipes to test his taster.

Editor's Note: We wish to thank you, Karen Derrick, R.D. for compiling the calories and exchanges for each recipe. Karen is employed at the Midwest Diabetes Center in Columbia, Missouri and is also the Dietary Director at Camp Hickory Hill, a summer camp for diabetic children; Karen is Type 1 diabetic, and she and her husband have a 1 year old son.

Marsh's Quick Stew

Marsh Mayry, Rapid City, SD

Ingredients:

1 lb. Browned stew meat

2 pkg. Brown, mushroom, or onion gravy mix (a combination of these works fine)

1 cup Frozen beans, peas, corn and broccoli (any vegetable one desires can be used)

2 cups Frozen potato wedges or 1 can of potatoes or onions, if desired.

Instructions:

Brown stew meat. Place in baking dish or crockpot. Add gravy mixes prepared as package states. Add other ingredients. Season with favorite spices. I use dill, garlic, and pepper. Bake in oven or crock pot until meat is tender.

Yield, number of servings: Six or 1 Hungry Finlander

Calories per serving: 240

Diabetic exchanges: 2 meat
1 bread

Sugarless Pumpkin Pie

Frances Allen, Columbia, Mo.

Put these ingredients into your blender in this order:

1 16 oz. Pumpkin or 1½ cup of fresh cooked pumpkin

2 tsp. Sweet-N-Low

½ tsp. of each of these:
salt
ginger
nutmeg

Spoon stir spices into pumpkin:

2 tsp. cinnamon

2 eggs

1 14 oz. can skim evaporated milk

Instructions:

Mix on medium speed. Pour into unbaked pie crust. Bake 425 degrees -15 minutes. Bake longer if needed. If knife comes out clean after insertion pie is done. When cooled, Equal may be sprinkled over pie. Top cooled pie with D-Zerta whipped topping mix.

Yield, number of servings: 8

Diabetic exchanges: 1½ bread
1½ fat

Number of calories per serving: 185

Diabetic Granola Bars

Ken and Linda Carstens, Virginia, MN

Ingredients:

¾ cup grapenuts

1 ¼ cup uncooked rolled oats

½ cup raisins

½ cup peanut butter

2 tsp. vanilla

2/3 cup water

4 tsp. honey

Instructions:

Mix together, adding water last. Some people prefer to use a little less water. Divide into portions and freeze. Eat frozen.

Yield, number of servings: 12 servings

Calories per serving: 157

Diabetic exchanges: ½ med. Fat meat
1 bread
½ fat
½ fruit

Apple Crisp

Carol Anderson, Randolph, NJ

Ingredients:

4 cups peeled, sweet apples

¼ cup water or apple juice

4 tsps. brown sugar substitute

2 tsps. lemon juice

¾ tsps. cinnamon

½ cup oatmeal, uncooked

2 Tbsps. chopped walnuts

1 Tbsp. brown sugar substitute

1 Tbsp. soft vegetable oil margarine

Instructions:

Combine apples, water (or juice), brown sugar substitute, lemon juice, and cinnamon; toss lightly to coat apples. Layer on bottom of 8-inch baking dish.

Heat oven to 375 degrees. Combine oats, nuts, and brown sugar substitute. Add margarine and mix well. Sprinkle over apples. Bake about 30 minutes. Serve warm or chilled.

Number of servings: Four

Calories per serving: 201

Diabetic Exchanges: 1½ fat
1 fruit

Breaking Away

by Joyce Scanlan

(Reprinted from the **Blindside**, Summer, 1984)

Blind persons who are members of the National Federation of the Blind work to paint a positive image of blindness. We say that, "The average blind person can do the average job in the average (or normal) place of business." We say: "It is respectable to be blind." Our collective experience tells us this. If we who are blind Americans are ever to take our rightful place as normal citizens, we must banish the image of the helpless and hopeless blind person.

At the same time there are other organizations purporting to "help" the blind, who persist in declaring that "Ninety percent of blind people are confined to their homes and cannot be trained to use the regular bus system." These are blind people, too, but their goal is different from ours. They wish to maintain the familiar and comfortable status quo and fear any change whatsoever. They tell the community that blindness is a tragedy and, in order to enjoy the benefits of society, blind people require numerous specialized services.

Public officials, such as legislators or the Commissioner of the Minnesota Department of Human Services, when confronted with blind persons from the Federation asking for their help in making needed changes, often say, "Why don't all you blind people get together?" As a further attempt to discount or discredit us, they will say, "Not everyone agrees with you people in the Federation."

Blind people are not all alike; blindness is our only common characteristic. In every other way we are as diverse as any group of individuals. We cannot "get together" with those who believe the exact oppositie of what we believe any more than the theists and the atheists or the Ku Klux Klan and the NAACP can "get together." Of course, all of those groups are Americans, and the same kind of logic might be employed: "Why can't all of you Americans (theists, atheists, members of the Ku Klux Klan, and members of the NAACP) get together?"

Furthermore, the fact that some people do not agree with us does not mean we're wrong. We understand that this, too, is another effort to pursue a do-nothing path by claiming that blind people do not comply with a standard which is not and cannot be applied to any other group. Not all Lutherans agree; neither do all educators. Yet, how many public officials could stand for election very long without dealing with substantive issues affecting Lutherans or educators?

The experience of thousands and thousands of blind people flies in the face of the catastrophic view of blindness. Despite the destructive statements of some blind individuals alleging that blind persons are homebound and can be taught to do only the simplest tasks, Federationists will press forward until the myths and stereotypes about blindness have been removed. Blind people can be independent and lead meaningful lives.

After all, we are not the first minority group ever to surmount the obstacles of an opposing view and come out victorious. During the American Revolution, there were colonists (Tories) who argued for remaining subjects of Great Britain; if a vote had been taken, would the proponents of independence have sustained even a bare majority? And when the Civil War was underway, weren't there some slaves who fought for the South, fearing the reprisals of their masters and perhaps gleaning comfort in the status quo?

Why, then, is it so surprising when blind people have conflicting views when it comes to freedom and independence? The truth is simply that we must adhere to our beliefs and not be dissuaded by the fears of status quo blind individuals or public officials. We are all Americans today because the proponents of independence prevailed. Slavery is no longer legal in our country because advocates of freedom overpowered those who would oppress the human spirit and thwart the advancement of people.

Although change can be frightening, change will take place for blind people just as it did for the American colonists and the blacks who are today free from British domination and the oppression of slavery. The time will come when blind people, too, will be free, and everyone will loudly proclaim that freedom belongs to all Americans — including the blind.

My Insulin Reaction

by Carol Anderson

It was the last week before Christmas. I was busy getting ready for the holiday and working at my various volunteer jobs. It was over a year since my kidney transplant, and I was doing as many activities as I could now that I was feeling well. My recuperation had taken many months, but I was now finally "getting back into the world" again.

The Saturday before Christmas I was volunteering as a receptionist at a local museum and then was going to a small Christmas party. I knew the woman giving the party, and she had been preparing the food for a whole week. So I ate sparingly that day, saving my appetife for the party. Being that I am a diabetic and take insulin, I realized this was the wrong approach, but I felt I could handle it. Nothing had happened to me in the past.

I arrived at the party about 7 p.m. feeling a little hypoglycemic, so I began to eat a few of the hor d'oerves. My condition did not improve, as it did usually, so I started drinking a glass of soda. I felt myself getting weaker and weaker until I passed out. Luckily, I was sitting at a table and didn't fall.

The next thing I remember is waking up with all of the guests at the party standing around the table looking at me. The hostess had known I was a diabetic, and when I passed out she tried to give me orange juice. That had not helped, and after twenty minutes she decided to call the rescue squad. When they arrived, intravenous glucose was administered, and I came out of it immediately. Because I had been unconcious for half an hour, the rescue squad took me to the local hospital to make sure I was alright.

At the hospital the emergency room physician examined me, and even though I was feeling fine, he suggested I go to the hospital where my personal physician could examine me. I agreed.

It was a busy night for the emergency room at the next hospital. I was wheeled in and talked to a doctor who said I could leave as soon as he briefly examined me. Since I was not in an emergency situation, he left me to attend more serious cases.

Lying there, I began to feel very strange. I started to shake with chills, my body felt achy, and I could not breathe properly.

When the doctor came back in, he knew something was wrong. Immediately he ordered a chest x-ray and blood tests to determine the oxygen content of my blood. The results of these tests suggested that I had pnewmonia. The doctor's rationalization for this occurring so quickly was that I probably aspirated some food or juice when I was unconcious and developed "aspirated pneumonia." I was admitted to the hospital to receive antibiotics intravenously.

The course of treatment lasted for a week, and I spent Christmas in the hospital. I did feel well enough to go out on a pass on Christmas day for a few hours for which I was truly grateful. I recovered quicker than usual according to my doctors and was discharged two days after Christmas.

I consider myself extremely lucky to have "bounced back" and hope to be encouraging to others who face problems. I would like to hear from anyone who has had a problem and how they coped with it. I know from my experience that I will never "save my appetite" until the end of the day and then eat a lot. It just doesn't work when you are a diabetic.

Please contact me. My name is Carol Anderson and my address is 23 Lake Shore Drive South, Randolph, NJ 07869. Telephone number: 201-895-3166.

THANK YOU

It has taken much help to make this newsletter a success. We of the Diabetic Division of NFB give our sincerest thanks to:

Gary Wunder, Senior Analyst Programmer, University of Missouri Hospital and Clinics Department of Pathology and President of NFB of Missouri, for preparing our mailing labels in zip code order.

A large group of volunteer workers headed by the very capable Ms. Arna Watson at the Oak Towers Retirement Home in Columbia, Missouri. Although too numerous to mention individually, this group donates many hours towards preparing the newsletter so that it meets postal regulations for mailing.

The National Federation of the Blind of Missouri for use of their bulk mailing permit.

Daniel Boyd, Director of the South Dakota State Library for the Blind and Physically Handicapped, for duplicating and distributing tapes at no cost to our division.

Last but by no means least, The National Federation of the Blind, our parent organization which has provided the grant that makes our newsletter possible.

There are literally hundreds of volunteer hours donated so that our newsletter can be published at the rates we charge. It is impossible to thank everyone who helped in this column, so to everyone who assisted we say THANK YOU!

Eulogy for a Federationist

by the Diabetic Division of NFB

On Wednesday, July 23, Joyce Miller passed away in her sleep. She was 34 years old. She had experienced many chronic diabetic complications and, after living with it for years, the disease finally took its toll. Joyce was an active Federationist and made substantial contributions to our organization. She served as Vice President of the St. Joseph chapter of the NFB of Missouri and was a charter member of the Diabetic Division.

Joyce knew there were no guarantees in life but realized she had to be a fighter to be a survivor. She, of course, wished that she did not have diabetes, but her big dream was that she, as an adult, be treated like other people, be allowed to have dignity and not be excluded from social settings.

As Joyce was in the hospital often, she also felt the education about blindness for physicians, nurses and health educators was essential.

Her parents say that Joyce's special love was the Diabetic Dibision of the National Federation of the Blind, and all memorial gifts sent will go to the division.

We, the Diabetic Division, commemorate her life, and if you have it in your heart to make a donation in memory of Joyce Miller, then please make it payable to the National Federation of the Blind and send it to the editor, Ed Bryant.

Those of us who knew Joyce will always remember her as a vivacious, outgoing person who did whatever she could to help other people.

Joyce, from your many friends we say farewell, and may you rest in peace. In memory of Joyce we convey a thought that she exemplified throughout her life: "Don't let your defeats defeat you."

Tidbits and Humor

We apologize

In our last newsletter, July-September, there was an excellent article by Dr. C. Edwin Vaughan. He is a professor in the Department of Sociology at the University of Missouri-Columbia. We incorrectly said that Dr. Vaughan was an Associate Professor. Again, Professor Vaughan, we apologize for the error.

Newletter Cassettes

Due to mechanical malfunctions, we have been having trouble getting a good, clean cassette recording or, in effect, newsletter cassettes have not been of top notch quality.

At this writing it is planned that these problems will be rectified and any reoccurance will be henceforth circumvented. Also, our first edition, Vol. #1, January-March, 1986 was not of good quality. Some people said they had trouble understanding their cassette and that it sounded like a duck under water. We have had the first edition rerecorded, and anyone desiring a cassette of this volume which does not have to be returned should send $1 to Ed Bryant.

Q: Why did the radish kiss the banana?

A: Because he has a peel.

Do you like print, cassette or both?

Any Diabetic Division member is entitled to a print copy of our newsletter. If you are blind or visually impaired, you may have a cassette copy at no additional cost. These tapes are provided by the South Dakota State Library for the Blind and Physically Handicapped and must be returned.

If you are blind, you may also receive our newsletter in both print and on cassette at no additional charge.

Many times a blind person will have a loved one who would be most interested in reading our publication. If you are a member of the Diabetic Division of NFB and are not receiving our newsletter in the medium(s) you prefer, please contact the editor.

Q: How do you catch a unique bird?

A: Unique up on him.

Membership Renewal

In July at our NFB National Convention, diabetic division members voted to increase membership dues from $1.00 to $2.00. We ask that if you have not renewed your membership then please send $2.00 payable to: THE NATIONAL FEDERATION OF THE BLIND. Please send to our treasurer: Carol Anderson, 23 Lake Shore Dr. S., Randolph, N.J. 07869.

Q: How do you catch a tame bird?

A: The tame way.

Free Bible Cassettes For the Blind or Visually Impaired

FREE bible cassette tapes of the Old and New Testaments, plus Bible Messages and Bible Studies in English and many other languages are available, as a gift, FREE OF CHARGE, to every person of low vision, visually impaired or blind, and to every person who has a physical disability which permanently affects their ability to read.

Orders from individuals should include written certification of blindness or reading impairment from a source recognizable by the Library of Congress, National Library Service for the Blind and Physically Handicapped, such as an organization for the blind or visually impaired, a rehabilitation teacher, a librarian or physician, etc.

The material will be sent "Free Matter for the Blind" within 6 weeks. Further details available on request by writing to: Bible Alliance, Inc./Bible Alliance Mission, Inc., P.O. Box 1549, Bradenton, FL 33506, (Phone 813-748-3031).

Quotation from Leo F. Buscaglia, PhD from his book **Living, Loving Learning**, published by Slack, Inc. The quotation reads as follows: "What did you learn today? As long as you learn, there is growth. Then there is life."

A Time of Stars
from Frances Allen
Columbia, MO

Christmas is a time of stars on
candle tips, in flakes of snow,
Polished in the frozen sky,
Heart warm in eyes that glow,
The sparkle in each carol,
Crown every fragment tree.
Shedding across the darkness,
Promise of peace to be.

Change of Address

Please notify our division president, Karen Mayry, of any address changes. We must have your correct address to insure that you receive a newsletter, as bulk-rate mailing is not forwarded.

Make your "Voice" heard

Since your editor is ultimately responsible for this publication, he needs to know of any foul-ups or goofs. He also welcomes any suggestions, recommendations and/or criticisms. We invite you to send questions for Dr. James, recipes for the Food Corner and articles that would interest our readers. Send all your great ideas to the editor, Ed Bryant.

What You Always Wanted To Know But Didn't Know Where to Ask

(Resource List)

The National Federation of the Blind (NFB) has over 50,000 members. It is the largest organized group of blind people in the world. NFB has accumulated lots of information on all subjects relating to blindness. You are cordially invited to contact the National Federation of the Blind with any questions that you might have. We are located at 1800 Johnson Street, Baltimore, MD 21230. Phone: (301) 659-9314.

We do not endorse all of these products and/or materials, but are simply stating their availability.

Sugarfree Kids' Cookery and **Sugarfree Sweets and Treats**, both by Judith Majors and both approved by the Oregon State Affiliate of the ADA. **Sweets and Treats** recipes are sweetened with fruit and fruit juices — no sugar or artificial sweeteners (128 pp.) **Kids' Cookery** recipes are easy for a young diabetic to prepare. (140 pp.) Both are available through the Sugarfree Center, Inc.:

#9022 **Sugarfree Kids' Cookery** $4.95

#9030 **Sugarfree Sweets and Treats** $4.95

To order call toll-free 1-800-972-2323 (California residents call 1-800-336-1222).

Health-O-Gram (H-O-G) is a bi-annual newsletter published by the Sugar free Center, Inc. It contains informative articles about all aspects of diabetes and an extensive resource listing of materials available through the center. To order a two-year subscription send $6.00 to:

Sugarfree Center Van Nuys
13715 Burbank Blvd.
Van Nuys, CA 91401
(818) 994-1093

H-O-G is available on cassette tape from the Braille Institute. The newsletter can be purchased for $2.41 per issue, or, if desired, you can receive it on loan (no charge) in which case it must be returned. Write to:

Braille Institute
741 North Vermont Avenue
Los Angeles, CA 90029-3594
(213) 663-1111

Also available in hand-copied braille from the Braille Institute:

Diabetic Exchange Lists, Northridge Hospital, 1 vol., 42 p.

Exchange Lists for Meal Planning, American Diabetes Association, 1 vol., 29 p.

Both exchange lists are also available in jumbo braille, grade 1 and grade 2:

Jumbo, Grade 1, 1 vol., 53 p.
Jumbo, Grade 2, 1 vol., 28 p.

Price: Thermoform braille materials are 9¢ per page and 75¢ for each volume for the binding and labeling.

Book on cassette tape:

Diabetes: A New and Complete Guide to Healthier Living for Parents, Children and Young Adults Who Have Insulin Dependent Diabetes, by Lee Ducat and Sherry S. Cohen. This tape is available through cooperating state libraries for the blind and physically handicapped.

Equipment: Plastic Insulin Gauges

*How to order: Send to following address a USED syringe and unit sizes needed. If insulin is mixed, state unit volume to be put into syringe first and unit volume to be put in last. Example: 4 units of ---x----- drawn into syringe first, then 20 units of ---y--- drawn into the syringe. So you need a 4 unit and a 24 unit gauge.

Cost:

1. $1.50 per gauge when payment is included with each order.
2. Orders received without payment will be billed at the rate of $2.50 per gauge.

Shipping: $1.50 for each 1 to 4 gauges ordered. Example: If 1 - 4 gauges, include $1.50; if 6 gauges, send $3.00.

*Note: Orders originating in Nebraska must include 5% sales tax.

*Note: Verify accuracy of gauge prior to usage. We make every effort to insure accuracy but confusion can occur. Therefore it is necessary to verify that the unit volume is correct prior to first use. Also, because of the manner in which syringes are manufactured, a variance of 1 to 3 units can occur between syringes, when using an insulin gauge. This does not occur frequently but consumers should be aware of the possibility.

Following the above procedure will insure fast, accurate service!

To order contact: Doug C. Boone
Boone's Kustom Kraft
P.O. Box 2641
Lincoln, NE 68502
(402)475-9185

1203 Fairview Rd.
Columbia, MO 65203

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